

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027321

FILED VS. JUL 27 1960 154

Registration District No. _____ Primary Registration District No. **5575** Registrar's No. **24**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Twp Gr andview, Mo.		Length of stay in lb 15 Yrs		c. CITY OR TOWN Grandview, Mo.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Rt. # 2			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rt. # 2		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TILLIE Middle A. Last SADLER				4. DATE OF DEATH Month July Day 24 Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Sept 22, 1895	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (City and state or country) Lake City, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Jacob Leavy			13b. MOTHER'S MAIDEN NAME Elizabeth Miller			14. NAME OF HUSBAND OR WIFE John B. Sadler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address John B. Miller, Rt, #2, Grandview, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							INTERVAL BETWEEN ONSET AND DEATH 30 MIN.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Diabetes Mellitus							20 YRS.	
DUE TO (c) Arteriosclerotic Heart Disease							20 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from 5-8-56 to 7-24-60 and last saw her alive on 7-19-60 Death occurred at 9:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) L. G. Hgee M.D.				22b. ADDRESS 5801 Kingles Drive, K.C. Mo.			22c. DATE SIGNED 7/24/60	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/26/60	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) Independence, Mo.		(State)	
24. FUNERAL DIRECTOR ADDRESS Geo. C. Carson & Sons, Independence, Mo.				25. DATE RECD. BY LOCAL REG. 7/24/1960		26. REGISTRAR'S SIGNATURE Herbert Dodard		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, IN

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.